HCFA LEGISLATIVE SUMMARY

September 13, 1982

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (P.L. 97-248)

On September 3, 1982, the President signed into law H.R. 4961, the "Tax Equity and Fiscal Responsibility Act of 1982." This new public law (P.L. 97-248) includes many provisions affecting the Medicare, Medicaid, and PSRO programs. Summaries of changes having a direct impact on HCFA programs are attached.

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Attachment

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982

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TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982

PROVISIONS AFFECTING THE MEDICARE PROGRAM

Medicare Reimbursement to Hospitals (Section 101)

Current Law: Medicare reimbursement for a hospital's inpatient routine operating costs (i.e., bed, board, and routine nursing) may not exceed 108 percent of the average routine cost per day incurred by other hospitals of the same type unless it qualifies for an exception or exemption.

Modifications:

223 Limits

- This provision extends Section 223 limits to include ancillary costs applied on a cost-per-case basis and adjusts each hospital's limit by a case mix adjustment. In no case would reimbursement on a cost-per-case basis be reduced below the allowable cost-per-case reimbursement for the hospital's cost reporting period that immediately precedes the first cost reporting period to which the new limitation is applicable. Limits are set at 120 percent of the mean in FY 1983, and reduced to 115 percent in FY 1984, and to 110 percent in FY 1985. The provision requires the Secretary to provide appropriate exemptions, exceptions and adjustments from the limits. Special adjustments are to be made for the needs of psychiatric hospitals and hospitals that incur additional costs in treating low income and Medicare patients. Non-SMSA hospitals with less than 50 beds on and after enactment are exempted from the limits.

  Effective Date: Cost reporting periods beginning on or after October 1, 1982.

Rate of Increase Limit

- The provision establishes a 3-year limit on a per case basis on the rate of increase in hospital revenue. The target rate is the previous year's allowable cost per case (or after the first year, the previous year's target amount) increased by the percentage increase in the hospital wage-and-price index, plus 1 percentage point. For the first 2 years, hospitals would be allowed 25 percent of those costs in excess of their rate of increase limit; none of the excess would be reimbursed in the third year. Hospitals with operating costs below the target rate of increase would be paid their costs plus a bonus of 50 percent of the savings (not to exceed 5 percent of the target rate). Provider payments could not exceed the amount payable under the new section 223 limitations. The Secretary would provide appropriate exemptions and adjustments to the target rate, specifically including an adjustment for psychiatric hospitals. The Secretary also is required to compute a reduction in payments to hospitals which

withdraw their employees from the OASDHI program after August 15, 1982. The reduction would reflect the savings achieved through withdrawal, but can be offset by expenditures for comparable insurance benefits.

Effective Date: Limits apply to a hospital's first 3 cost reporting periods beginning on or after October 1, 1982, but cease upon implementation of a prospective payment system.

Prospective Reimbursement

- This provision requires the Secretary to develop, in consultation with the Senate Finance Committee and the House Ways and Means Committee, Medicare prospective reimbursement legislative proposals for hospitals, skilled nursing facilities and, to the extent feasible, other providers.

  Effective Date: A report to the Committees on the proposals is due by December 31, 1982.

Recognition of State Hospital Cost Control System

- Medicare hospital payments could be made (at the request of a State) under a hospital reimbursement control system in the State if, and so long as, (1) the system applies to substantially all non-Federal hospitals to at least 75 percent of hospital inpatient revenues in the State, and to the State's Medicaid program, (2) the system treats payors, hospital employees, and patients equitably, and (3) the Secretary is satisfied that the system will not result in greater Medicare expenditures over a 3-year period. In making this determination, the Secretary could recognize previous cost savings under the system. The provision also prohibits the Secretary from terminating Medicare hospital reimbursement demonstration projects in continuous operation since July 1, 1977, such as Maryland, until 6 months after he notifies the State of his decision to terminate.

Single Reimbursement Limit for Skilled Nursing Facilities and Home Health Agencies (Sections 102 and 105)

Current Law: Regulations establish different reimbursement limits for skilled nursing facilities and home health agencies depending on whether they are hospital-based or freestanding facilities.

Modification: The provision requires the Secretary to issue regulations establishing a single reimbursement limit for skilled nursing facilities and for home health agencies, based on the cost experience of freestanding facilities. Exceptions could be made based on legitimate differences in hospital-based skilled nursing facilities resulting from factors such as more complex case mix or the effects of Medicare cost allocation requirements.

Effective Date: The provision applies to home health agency reporting periods beginning on or after the date of enactment, and skilled nursing facility cost accounting periods beginning on or after October 1, 1982.

Elimination of Nursing Differential (Section 103)

Current Law: Since 1969, Medicare has paid hospitals and skilled nursing facilities an additional amount for inpatient routine nursing salary costs on the theory that older patients require more nursing care than younger patients. The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) reduced, effective October 1, 1981, the hospital inpatient routine nursing salary cost differential from 8.5 to 5 percent.

Modification: The provision eliminates the routine nursing salary cost differential for both hospitals and skilled nursing facilities.

Effective Date: For cost reporting periods ending after September 30, 1982 but only for the portion of that period occurring after that date.

Elimination of Duplicate Overhead Payments for Outpatient Services (Section 104)

Current Law: The Secretary is required to establish, by regulation, limitations on costs or charges that are to be considered reasonable for outpatient services provided by hospitals or clinics (other than rural health clinics) and by physicians utilizing those facilities.

Modification: The provision allows the Secretary to issue regulations to limit the reasonable charge for the services of physicians who perform services in hospital outpatient departments to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account the extent to which the overhead costs of the department have been included in the hospital's costs or charges.

Effective Date: The provision applies to charges for services rendered on or after October 1, 1982.

Prohibiting Payment for Hill-Burton Free Care (Section 106)

Current Law: In obtaining Federal loan guarantees under the Hill-Burton Act, hospitals and skilled nursing facilities agree to provide a reasonable volume of uncompensated services to persons unable to pay. A recent U.S. Court of Appeals decision held that costs of providing such care were reimbursable under Medicare.

Modification: Requires the Secretary to provide, by regulation, that the costs incurred by a hospital or SNF in complying with its free care obligations under the Hill-Burton Act are not reasonable costs for purposes of Medicare reimbursement.

Effective Date: The provision applies to all such costs that have been, or will be incurred, except those recognized by the final judgement of a U.S. Court of Appeals entered into prior to enactment.

Prohibiting Payment for Anti-Unionization Activities (Section 107)

Current Law: The reasonable costs of consultants to hospitals on union organizing activities are recognized by Medicare if these activities do not violate the National Labor Relations Act.

Modification: Medicare reimbursement for costs incurred for activities directly related to influencing employees with respect to unionization would be prohibited.

Effective Date: The provision applies to costs incurred after the date of enactment.

Reimbursement of Provider-Based Physicians (Section 108)

Current Law: Current regulations provide that services furnished by a physician to hospital patients are reimbursed under Part B only if such services are identifiable professional services which contribute to the diagnosis or treatment of individual patients. All other services performed for the hospital (or for a skilled nursing facility) by provider-based specialists (e.g., radiologists, anesthesiologists, pathologists) are reimbursed as provider services on the basis of reasonable costs.

Modification: The provision directs the Secretary to prescribe regulations, which will distinguish between (1) professional medical services which are personally rendered to individual patients; which contribute to the patient's diagnosis and treatment; and are reimbursable under Part B on a charge basis, and (2) professional medical services of practitioners which are of benefit to patients generally and which can be reimbursed only on a reasonable cost basis. Reasonable cost reimbursement for provider based services cannot exceed a reasonable compensation equivalent established by the Secretary in regulations.

Effective Date: For reductions for cost reporting periods ending after September 30, 1982 but only for the portion of the period occurring after that date.

Prohibiting Recognition of Payments under Certain Percentage Arrangements (Section 109)

Current Law: In determining reasonable costs for home health agencies, the Secretary is to exclude any cost under a contract which determines the amount payable by the home health agency as a percentage of the agency's reimbursement or claim for reimbursement. There are no comparable provisions for other providers.

Modification: Payments made by any provider of services to contractors, employees of related organizations, consultants, or subcontractors would not be reimbursed where compensation is based on percentage arrangements except where such arrangements are reasonable and are part of customary

business practice or provide incentives for efficient and economical operations. The provision would also not apply where such costs are subject to limits contained in Section 108 of the bill on reimbursement of provider-based physicians.

Effective Date: The provision is effective upon enactment, except: (1) for percentage arrangements entered into before enactment, the provision applies one year after enactment, or (2) if the provider can unilaterally terminate a percentage arrangement, the provision applies 30 days after the first date that the provider can terminate the arrangement; (3) also, the provision would not apply prior to October 1, 1982 to costs incurred under a percentage arrangement for services of a provider-based physician. Beginning October 1, 1982, the provision would apply only where the limitation on the reimbursement for the services of provider-based physicians (as promulgated in regulations required by Section 108 of this Act) has not been implemented.

Eliminating "Lesser of Costs or Charges" Provision (Section 110)

Current Law: Payment for services furnished by providers is limited to the lower of the provider's actual charge or the reasonable cost of the service.

Modification: The "lower of costs or charges" (LCC) provisions would be eliminated for a class of providers, if and when the Secretary determines and certifies to the Congress that such action will not increase Medicare payments to that class of providers. The Conference Report expresses the intent that such determination would take into account both past experience under the LCC provision and possible changes in cost accounting and charging practices of providers in the absence of the provision. LCC would be re-established if the Secretary determines that its elimination has increased program costs.

Effective Date: The provision would be effective on the date the Secretary specifies in the certification to Congress.

Elimination of Private Room Subsidy (Section 111)

Current Law: Medicare currently determines its payments to a hospital on the basis of the average costs of all of its accommodations, including the additional costs of private rooms even though Medicare generally does not pay for private rooms that are not medically necessary.

Modification: The provision requires the Secretary to publish regulations eliminating the current Medicare subsidy for medically unnecessary private rooms.

Effective Date: Regulations are to be issued by October 1, 1982: if they are published on an interim basis, final regulations must be issued by January 31, 1983.

Radiologist/Pathologist (Section 112)

Current Law: Under current law, Medicare Part B pays 100 percent of the reasonable charges of radiologists and pathologists who furnish radiology and pathology services to hospital inpatients and who accept assignment in all cases for these services. Such services are not subject to the deductible and coinsurance features of the Part B program.

Modification: The provision eliminates the 100 percent reimbursement rate currently applicable to inpatient radiology and pathology services. Medicare will pay for such services on the same basis as for other physicians' services, i.e., 80 percent of the reasonable charge after the Part B deductible has been met.

Effective Date: The provision is effective for services furnished on or after October 1, 1982.

Reimbursement for Assistants at Surgery (Section 113)

Current Law: Part B carriers have the discretion of reimbursing assistants at surgery, and generally follow local medical practice and/or private sector reimbursement policies.

Modification: The provision prohibits reasonable charge reimbursement for an assistant at surgery in hospitals where an approved training program exists in the specialty and a qualified staff physician is available to provide the service, except when: (1) the surgery is performed by a team of physicians needed to perform complex medical procedures; (2) the patient has multiple conditions which require the presence of, and active care by, a physician of another specialty during surgery; and (3) in the case where exceptional medical circumstances exist. The Secretary may specify other appropriate exceptions by regulations.

Effective Date: The provision is effective with respect to services performed on or after October 1, 1982.

Prohibition of Payment for Ineffective Drugs (Section 115)

Current Law: The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35, Section 2103) prohibited, effective October 1, 1981, the use of Federal funds under Medicare Part B and under Medicaid to pay for certain drugs. These are prescription drugs that the Food and Drug Administration has determined to be less than effective in use. However, subsequent appropriations legislation barred implementation of Section 2103 of P.L. 97-35 through September 30, 1982 and the Department has provided for continued reimbursement of the drugs.

Modification: The provision authorizes implementation of Section 2103 of P.L. 97-35.

Effective Date: September 30, 1982.

Medicare Secondary for Older Workers (Section 116)

Current Law: The Medicare program is the primary payor except in cases of workers' compensation, third party liability, and a few other cases. The Federal Age Discrimination in Employment Act (ADEA), which applies to employers of 20 or more full-time employees prohibits employment bias on the basis of age for most workers between ages 40 and 70 in the private sector. However, the Department of Labor Interpretive Bulletin on the ADEA permits an employer to "carve-out" from his health plan those benefits that are actually paid for by Medicare. As an alternative, under certain circumstances, an employer can offer employees eligible for Medicare a separate plan that supplements Medicare.

Modification: This provision amends the ADEA by requiring employers of 20 or more employees to offer their employees age 65 through 69 and their dependents health benefits coverage under the same conditions as offered the employer's younger employees. These benefits must be offered as primary to Medicare for such employees (and their spouses aged 65 through 69).

Medicare's payments are made secondary to the employment-based insurance with respect to services provided to these older workers and spouses. Medicare's payment for any item or service furnished to an employee (or spouse), would be reduced where the combined payment under Medicare and the employer's health benefits plan would otherwise exceed an amount equal to: (1) the reasonable cost of items or services reimbursed on a cost or cost-related basis; or, (2) the higher of the reasonable charge (or other amount payable under Medicare, without regard to the program's deductibles or coinsurance) or the amount payable under the employer group plan (without regard to deductibles or coinsurance imposed under that plan) for items reimbursed on a charge basis. In no case would Medicare pay more than Medicare would have paid in the absence of any employer plan.

The Conference Report includes language specifying the intent of Congress that an employee will have the option of rejecting the plan offered by the employer, thereby retaining Medicare as primary coverage. The Congress expressed the intention that the Secretary of Labor issue regulations discouraging employers from attempting to induce employees over 65 to reject the general health benefit plan offered to employees under 65.

Effective Date: ADEA amended effective January 1, 1983. The amendment to the Social Security Act is effective with respect to items and services furnished on or after January 1, 1983.

Interest Charges on Overpayments and Underpayments (Section 117)

Current Law: Providers and suppliers of services who receive overpayments from the Medicare program are not charged interest either for the period during which they have use of the money or for the period during which repayment is being made. Similarly, Medicare pays no interest on any underpayment it makes to providers.

Modification: This provision requires interest payments with respect to Medicare overpayments and underpayments. The rate of interest would be in conformity with the Treasury Fiscal Requirements Manual. Interest would not begin to accrue until 30 days after the date of the final determination.

Effective Date: The provision is effective for final determinations made on or after the date of enactment.

Temporary Delay in Periodic Interim Payments (Section 120)

Current Law: Hospitals may elect to receive payments for services rendered to beneficiaries on the basis of periodic interim payments based on estimates of covered days. Under this method, lag between provision of service and receipt of payment averages 3 weeks. Providers paid on the basis of submitted bills experience an average lag of up to 6 weeks.

Modification: Delays PIP due during the last 3 weeks of September of both 1983 and 1984, to the following October.

Effective Date: September, 1983 and 1984.

Medicare Coverage of Federal Employees (Sections 121 and 278)

Current Law: Federal employment generally is not covered under Social Security and is therefore not subject to FICA taxes.

Modification: Medicare coverage would be extended to Federal employees, who would be required to pay the Hospital Insurance portion of the FICA tax (i.e., 1.3 % of earnings up to a yearly maximum). Federal wages earned after December 31, 1982 would be covered for purposes of earning quarters of coverage for determining Medicare eligibility. Persons employed by the Federal government as of January 1, 1983 and at any time prior to that date would, if necessary, have their wages prior to January, 1983 treated as if those wages were covered for purposes of determining Medicare eligibility.

Effective Date: Applies to wages paid in calendar years after 1982.

Coverage of Extended Care Services Without Regard to Three Day Prior Hospitalization Requirement (Section 123)

Current Law: Medicare provides coverage of up to 100 days of "post-hospital extended care services" in a qualified skilled nursing facility (SNF) following a hospital stay by the beneficiary of at least 3 consecutive days.

Modification: This provision would eliminate the 3-day prior hospitalization requirement when the Secretary determines it will not lead to an increase in cost and will not change the acute care nature of the SNF benefit. The Secretary is authorized to impose limits for persons covered without a prior hospital stay on the scope or extent of services

covered and on categories of individuals eligible. The 3-day requirement may be reestablished if the Secretary determines that its elimination has increased program costs.

Effective Date: At such time that the Secretary determines, through reimbursement changes or other adjustments, that elimination of the 3 day requirement will not lead to an increase in cost and will not alter the acute care nature of the benefit.

Part B Premium as a Temporary Constant Percentage of Costs (Section 124)

Current Law: Part B premiums are the lesser of the actuarial rate (that amount required to pay for one-half the expected monthly average cost of the Part B program, with a margin for error) for aged enrollees, or the past year's rate, increased by the same percentage as the most recent general cost of living adjustment (COLA) to monthly Social Security cash benefits.

Modification: From July 1983 through June 1985, the monthly premium for Part B is set at one-half the actuarial rate (25 percent of the expected average cost with a margin for error) for aged enrollees. After June 1985 calculation of the premium rate would revert to the current law method with the premium amount for July 1984-June 1985 serving as the base from which the July 1986 premium would be calculated.

Effective Date: July 1, 1983 through June 30, 1985.

Special Enrollment Provisions for Merchant Seamen (Section 125)

Current Law: Health benefits for merchant seamen under the Public Health Service (PHS) Act were repealed effective September 1981. Seamen who were eligible, but had not previously enrolled in Part A or Part B, had to wait for a General Enrollment Period and pay a late enrollment penalty under Part B.

Modification: A special enrollment period is established for merchant seamen beginning the first month that occurs at least 20 days after enactment and ending December 31, 1982. Seamen who can document their former PHS eligibility may enroll in Part A and in Part B without having to pay the late penalty, and can elect retroactive coverage to October 1, 1981 if they enroll before January 1, 1983. The Secretary will disseminate information to make seamen aware of this provision.

Effective Date: The first month occurring at least 20 days after enactment.

Extending Medicare Proficiency Examination Authority (Section 126)

Current Law: The Secretary of HHS is authorized to conduct a program to determine the proficiency of health care personnel, including clinical laboratory personnel who do not meet formal educational requirements. The existing authority expired December 31, 1981.

Modification: The authority of the Secretary to determine the proficiency of certain health care personnel would be extended to September 30, 1983.

Effective Date: The provision is effective upon enactment.

Prohibiting Retroactivity of Regulations Regarding Access to Books and Records (Section 127)

Current Law: Section 952 of Public Law 96-499 (the Omnibus Reconciliation Act of 1980) requires the Secretary of HHS or the Comptroller General to have access to the books and records of subcontractors who supply providers with goods and services valued at $10,000 or more over a 12 month period. The law directs the Secretary to prescribe in regulations the procedures and criteria to be used in obtaining access to such books and records. These regulations have not yet been published in proposed form.

Modification: If regulations implementing Section 952 are not issued in final form prior to January 1, 1983, preceded by a comment period of at least 60 days, they may not be applied retroactively.

Effective Date: The provision is effective upon enactment.

PROVISIONS AFFECTING THE MEDICAID PROGRAM

Copayments by Medicaid Recipients (Section 131)

Current Law: States are authorized to impose nominal cost sharing charges on Medicaid recipients, except for mandatory services provided to the categorically needy.

Modification: States are permitted to impose nominal copayments in all cases except no copayments may be imposed for any services provided to categorically and medically needy children under 18 (or up to 21 at State option) or to categorically and medically needy institutionalized persons who are required to spend all their income for medical expenses except for a personal needs allowance; copayments may not be imposed on pregnancy-related services (or any services provided to pregnant women at State option) or emergency and family planning services and supplies provided to categorically and medically needy recipients; copayments are also prohibited for services delivered to categorically needy HMO enrollees (medically needy at State option).

Existing regulations defining "nominal" should be used as the basis for determining whether proposed changes meet statutory requirements. The conferees intend that the Secretary adhere in promulgating regulations to the requirements for notice and opportunity for comment contained in the Administrative Procedures Act. If existing regulations defining "nominal" are changed, the levels of cash assistance in the States should be considered. The Secretary may waive the copayment provision for demonstration purposes only when certain very specific conditions are met. The Secretary also may waive the nominal copayment provision to permit charges up to twice the nominal amount for nonemergency services provided in hospital emergency rooms where alternative nonemergency, outpatient services are available. Finally, participating providers may not deny care to an individual because of an inability to pay cost-sharing charges, but this does not eliminate the beneficiary's liability for the charges.

Effective Date: October 1, 1982 except where State legislation is necessary, the State shall not be considered out of compliance before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.

Modifications in Lien Provisions (Section 132)

Current Law: States may recover medical assistance costs from the estates of aged Medicaid recipients, but they may not place liens on the property of Medicaid recipients prior to their death. Also, there may be no recovery against the estate if the recipient's spouse is still alive or if there are minor (or blind or disabled) children. In determining eligibility for SSI, States may count as a resource the uncompensated value of an asset transferred for less than full market value. Transfers of the home are exempt from being counted as a resource.

Modification: States are permitted to impose liens on property, including homes, of institutionalized Medicaid recipients if it is determined, after notice and opportunity for a hearing, that they are likely to be institutionalized for the remainder of their lives. Liens may not be imposed on homes if a spouse or disabled or dependent child lives in the home, or if a sibling with equity in the home who has lived there at least a year before the recipient was admitted to the nursing home resides in the home. Liens may not be closed until the recipient's spouse dies and there are no dependent or disabled children; in addition, liens on homes may not be closed until there are no siblings (who had resided in the home for one year prior to the recipient's institutionalization) or adult children (who had resided in the home and provided care for two years prior to the recipient's institutionalization) residing in the home.

The intent of the statutory change affecting transfers of the home, as reflected in the conference report is as follows: States are permitted to deny Medicaid eligibility for persons who transfer their homes for less than full market value. Ineligibility would last for 24 months from the date of the transfer, except where a longer or shorter period is warranted based on the relationship between the uncompensated value of the home and the cost of 24 months of Medicaid care in a SNF. The law provides certain exceptions to the imposition of this penalty; in addition, States are permitted to waive the penalty in cases of undue hardship.

NOTE: There is an error in the drafting of this statutory change which may nullify its impact. Because of this apparent drafting error, the provision states that a person who transfers a home for less than full market value remains eligible for medical assistance if the individual cannot be expected to return home, rather than if the individual can be expected to return home.

A change has been made to the general Medicaid transfer-of-assets language to permit States to waive their own rules in cases of undue hardship.

Effective Date: Upon enactment, but does not apply to transfers of assets which took place prior to enactment.

Limitation on FFP in Erroneous Medical Assistance Expenditures (Section 133)

Current Law: States are required (through an Appropriation Act provision) to reduce Medicaid payment error rates to 4% by September 30, 1982, in equal amounts each year beginning in FY 1980, or suffer fiscal penalties.

Modification: Beginning in the second half of FY 83 and for future fiscal years, matching to States with eligibility error rates greater than 3% will be reduced by the amount of the excess erroneous expenditures. The Secretary is permitted to waive the penalty in cerain limited cases based on a determination that the State has made a good faith effort to reduce its error rate to 3%. The Secretary shall consider expected erroneous payment levels in estimating payments to be made to States. In calculating the error rate, payments to ineligibles and overpayments to eligibles would be included; technical errors would be excluded; where errors are made in determining eligibility based on "spending down", only the smaller of the amount of medical assistance provided or the amount of the spend-down that was miscalculated will be considered erroneous (this is current policy); and in determining resource errors, only the smaller of the amount of medical assistance provided or the amount of the resource that was miscalculated will be counted as erroneous (this changes current policy).

Effective Date: Upon enactment. (However, as a practical matter, implementation is delayed until the second half of FY 83).

Medicaid Coverage of Home Care For Certain Disabled Children (Section 134)

Current Law: The income of parents is deemed to be available to SSI and Medicaid applicants or recipients including disabled children who live with their families. In States that base Medicaid eligibility on SSI rules, the family income is not deemed to be available to children residing in institutions. The Secretary is permitted to waive the provision deeming the income of parents to children living with their families if he determines that this requirement is inequitable.

Modification: States are permitted to cover under Medicaid certain disabled children age 18 or under who live at home. This applies to children who would have been eligible for SSI, and hence Medicaid, had they been institutionalized. If States choose this option, they must determine that the child would have required institutional care, providing care at home is appropriate, and the estimated cost of care at home is no more expensive than the institutional care would have been.

Effective Date: October 1, 1982.

Six-Month Moratorium on Deregulation of Skilled Nursing and Intermediate Care Facilities (Section 135)

Current Law: The Secretary is authorized to promulgate regulations related to Medicare conditions of participation for SNFs, Medicaid certification and requirements for SNFs and ICFs, and certification procedures for providers.

Modification: This provision imposes a six-month moratorium on the promulgation of changes in current regulations related to Medicare conditions of participation for SNFs, Medicaid certification and requirements for SNFs and ICFs, and certification procedures for SNFs.

Effective Date: Moratorium continues until the first day of the seventh calendar month beginning after the date of enactment.

Medicaid Program in American Samoa (Section 136)

Current Law: Federal funding is not available to American Samoa for Medicaid.

Modification: Federal funding for Medicaid services in American Samoa is available at a matching rate of 50% and up to a maximum of $750,000 annually. In providing such funding, the Secretary may waive or modify any Title XIX requirement except for the matching rate and the maximum annual funding level, and the requirement that medical assistance payments be made only for Medicaid covered care and services.

Effective Date: October 1, 1982.

AUDIT, MEDICAL CLAIMS REVIEW, UTILIZATION AND PEER REVIEW

Audit and Medical Review (Section 118)

Current Law: Medicare fiscal intermediaries and carriers perform provider cost audits and medical necessity review (to the extent it is not duplicative of PSRO review) of claims using funds appropriated for Medicare contractor budgets. The amount to be spent on audits and medical review is negotiated by each contractor.

Modification: The Medicare contractor budget will be supplemented by an additional $45 million for Fiscal Years 1983, 1984 and 1985 which must be used exclusively for provider audits and medical necessity review.

Effective Date: October 1, 1982.

Private Sector Review Initiative (Section 119)

Current Law: Medicare fiscal intermediaries and carriers perform medical review (to the extent is is not duplicative of PSRO review) of claims and their performance is monitored.

Modification: The Secretary will undertake an initiative to improve medical review performed by Medicare contractors, and will encourage similar efforts by private insurers and other private entities. Specific standards must be developed to measure the performance of Medicare contractors in identifying and reducing unnecessary utilization. Current provisions which waive beneficiaries' liability for payment of services they did not know would be uncovered are confirmed for payment denials made under the review initiative.

Effective Date: Upon enactment.

Utilization and Quality Control Peer Review Program (Section 143)

Current Law: Non-profit Professional Standards Review Organizations (PSROs), composed of licensed physicians in designated local areas, are required to review the medical necessity, quality and appropriateness of health care services provided to Medicare beneficiaries. PSROs receive a Federal grant to perform this review, as well as to analyze profiles of care to identify aberrant patterns. States may contract with PSROs for Medicaid review at a Federal match of 75 percent of the costs. PSROs may not disclose information unless necessary for program purposes, and cannot be held liable on account of any action resulting from the performance of review duties. Physicians and providers failing to meet their obligations under the law may be sanctioned by PSROs.

Modification: The PSRO program is modified by establishing the Utilization and Quality Control Peer Review Organization (UQCPRO) program in its place. The UQCPRO program is very similar to the PSRO program with several important differences. Eligible organizations may be proprietary or non-profit and may be either physician groups or have available sufficient physicians to perform review. Facilities and facility associations are excluded from participating; payor organizations may participate after 12 months. The Secretary will enter into performance contracts with UQCPROs for two years, renewable biennially. Contracts could be terminated only after a panel had reviewed relevant data and information and provided a recommendation to the Secretary. Contract non-renewals would not be subject to termination panel procedures but the UQCPRO would be able to present data and information on its performance. Geographic areas would be consolidated generally into Statewide areas if annual Medicare and Medicaid admissions are fewer than 180,000. No local area could be established with fewer than 60,000 total (both public and private) annual admissions. UQCPROs will be exempt from the Federal Freedom of Information Act but must disclose relevant information to Federal and State fraud and abuse, licensure and public health agencies. Sanctions will automatically become effective within 120 days if the Secretary fails to act upon a UQCPRO recommendation. The dollar amount triggering hearings and appeals of review decisions has been doubled. Private review is facilitated by requiring participating Medicare hospitals to release data on patients of private payors who contract with UQCPROs. The Secretary cannot terminate or fail to renew any PSRO grants until he enters into a contract with a UQCPRO for the area served by the PSRO. The UQCPRO program has no provision for Statewide or National Councils.

Effective Date: With contracts entered into or renewed on or after enactment (subject to the provision requiring continuance of PSROs pending contracting with UQCPROs).

HOSPICE CARE (Section 122)

Current Law: Covered services are provided to terminally ill beneficiaries and may be provided in a hospice setting. However, unique hospice services such as outpatient palliative drugs, respite care, bereavement counseling and home health services provided to beneficiaries who are not homebound are not covered and cannot be reimbursed. Hospices are not recognized as distinct providers, although some have been certified under other provider categories.

Modification: Medicare Part A will cover hospice care for beneficiaries having a life expectancy of 6 months or less. Hospice care is available for two periods of 90 days and one period of 30 days in lieu of all other Medicare benefits, except the patient's attending physician and services not related to the terminal condition. Hospices must provide a core of services directly which include nursing care, medical social services, physician services and counseling services. All other services including physical and occupational therapy, speech-language pathology, home health aide/homemaker services, drugs and medical supplies and short-term inpatient care can be provided under arrangements. Inpatient care can comprise no more than 20 percent of aggregate patient days, with inpatient respite care limited to no more than 5 consecutive days on an intermittent basis. A 5 percent coinsurance is imposed on inpatient respite care and a copayment is placed on drugs at the lesser of $5 or 5 per cent per prescription charge. Care must be available on a 24-hour basis and be provided in accordance with a written plan developed and implemented by an interdisciplinary team composed of one physician, one nurse and one social worker employed by the hospice, as well as one counselor. Hospices are classified as separate providers which must file separate cost reports. Organizations will be deemed to meet any hospice standards identical to standards they currently meet under other provider categories. Reimbursement will be made on the basis of reasonable cost, not to exceed a cap amount equal to 40 percent of the estimated average Medicare expenditures for cancer patients during the last six months of life. No payment may be made for bereavement counseling, and other counseling services may not be rendered as separate services.

The Secretary will report to Congress by January, 1986 on the equity of the reimbursement method and benefit structure, including the feasibility of prospectively reimbursing hospices. The Secretary will also report, prior to September 30, 1983, on the effectiveness of the hospice demonstration program, which will be continued until implementation of this provision.

Effective Date: November 1, 1983 with a sunset provision of October 1, 1986.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS (Section 114)

Current Law: Health maintenance organizations (HMOs) are reimbursed by Medicare for services covered under both Parts A and B, pursuant to Section 1876 of the Social Security Act. Section 1876 defines an HMO as a legal entity which generally meets the definition in Title XIII of the Public Health Service Act, and which makes Medicare covered services available in a geographic area on a prepayment basis.

Under Section 1876, HMOs receive interim monthly capitation payments based on either cost or risk contracts. An HMO is eligible to enter into a risk-sharing contract if it has at least 25,000 members and has served as the primary source of health care for at least 8,000 persons in the two years immediately preceding the contract, or serves non-urban areas with current enrollments of not less than 5,000 members and which has served as the primary source of health care for at least 1,500 people in the 3 years immediately preceding the contract.

Under risk contracts, reimbursement is based on a comparison of the HMO's costs with its Adjusted Average Per Capita Cost (AAPCC), which is the average cost of providing services to Medicare beneficiaries in the same geographic area as the HMO but who are not enrolled, and having the same characteristics as the enrolled population. If the risk-based HMO's costs are less than the AAPCC, it shares the "savings" with the Medicare program. The organization may receive savings of up to 10 percent of the AAPCC. HMOs are not required to provide additional services with their savings.

Modification: In addition to cost contracts, the provision authorizes prospective reimbursement under risk sharing contracts with HMOs and other eligible organizations at a rate equal to 95 percent of the AAPCC.

Organizations eligible to enter into contracts are Federally-qualified HMOs or organizations which provide specified health services, receive fixed and periodic payments on behalf of enrollees, provide physician services through staff physicians or physicians under contract, assume financial risk on a prospective basis, and meet financial viability standards. The organization must have at least 50,000 members, although this limitation may be waived for plans in non-urban areas. The organization must provide all Medicare services and the Secretary must approve any additional services. The organization must also have arrangements for an ongoing quality assurance program, in accordance with regulations to be established by the Secretary.

An annual open enrollment period of at least 30 days is required. Plans must generally accept beneficiaries in order of application up to capacity. A beneficiary may disenroll on a monthly basis with one month's notice. A plan may not disenroll or refuse to reenroll a beneficiary because of health status or services required. Combined Medicare and Medicaid enrollment in the HMO cannot exceed 50 percent of the total enrollment, except under certain circumstances. The Secretary may establish standards for consumer information to be supplied to eligible beneficiaries.

To the extent that the Medicare payment exceeds the eligible organization's adjusted community rate under a risk-sharing contract, the organization must use the savings to provide its Medicare members with additional benefits (selected by the organization and approved by the Secretary) or reduced cost sharing.

Two new Medicare members will be required to enroll in a plan for each current Medicare enrollee who converts to risk reimbursement.

The Secretary may enter into reasonable cost contracts with eligible organizations which he or she determines do not have the capacity to bear the risk of potential losses under a risk-sharing contract, or which so elect, or which do not meet the membership size limitation.

The Secretary is required to conduct a study on the benefits, in addition to Medicare benefits, which are provided under the new risk reimbursement; and another study on the extent of, and reason for, Medicare beneficiaries terminating membership in HMOs.

Effective Date: The provision will become effective the later of the first day of the thirteenth month after enactment, or one month after the Secretary notifies Congress that he is reasonably certain that the methodology for determining the prospective rate based on 95 percent of the AAPCC is developed and can be implemented.

TECHNICAL CORRECTIONS FROM OMNIBUS BUDGET RECONCILIATION ACTS OF 1980 AND 1981 (Sections 128 and 137)

Current Law: The Omnibus Budget Reconciliation Acts of 1980 and 1981 authorized many changes to Titles XVIII and XIX of the Social Security Act.

Modification: Section 137 makes a number of technical and minor policy changes to the 1981 Reconciliation Act. The policy changes are as follows:

Section 137 (a)(4) For the State plan requirement that States inform all eligibles of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services as mandated in P.L. 97-35, an exception to the effective date of 10/1/81 can be made where action by the State legislature is required to make plan changes. In such cases, previous EPSDT informing requirements remain effective under Title XIX after 10/1/81.

Section 137 (b)(7) This provision clarifies that States can cover certain groups as optional categorically needy and removes the ambiguity in the Reconciliation Act which appeared to preclude such coverage unless a State adopted a medically needy program. If States cover any optional categorically needy groups, they must provide them with at least the mandatory services.

Section 137(b)(8) This provision specifies that a single income/resource standard (varying only by family size) be used for all medically needy groups. In determining income and resources, the methodology of the appropriate cash assistance program will be used.

Section 137(b)(9)	This provision specifies that if a State covers any groups of persons as medically needy, it must cover all medically needy children under 18 in groups which parallel the groups the State covers as categorically needy, rather than only a reasonable category of children under 18.
Section 137(b)(11)	This provision exempts Federally qualified HMOs from Utilization Control requirements.
Section 137(b)(12)	This provision extends annual (rather than every 60 days) recertification of care to all Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) instead of only public ICF/MRs.
Section 137 (b)(15)(B)	This provision excludes payments for services provided by Indian Health Service (IHS) facilities and payments to State Medicaid Fraud Control Units (SMFCU) from inclusion in the determination of the reduction in Medicaid payments to the States as authorized in P.L. 97-35.
Section 137 (b)(15)(F)	This provision expands the definition of "third party and fraud and abuse recoveries" as used in calculating reductions to the Medicaid reduction provision authorized in P.L. 97-35. Amounts not expended because of provider suspensions for fraud and abuse will now be included in making such calculations.
Section 137 (b)(16)(A)	This provision modifies the target rate provision to make it consistent with Section 137(b)(15)(B) excluding IHS and SMFCU payments from calculation of Medicaid reductions.
Section 137 (b)(16)(E)	This provision removes, for purposes of calculating States' target rates only, the effect of changes after FY 1981 in States' Federal medical assistance percentages.
Section 137(b)(19)	This provision repeals the authority of the Secretary to waive for purposes of restricting freedom of choice the requirements included in 1903(m) (the HMO Section). The revised provision does not apply to waivers granted and in place prior to August 10, 1982. Also, the conference report states that the types of entities subject to 1903(m) requirements would not include contractual arrangements between the State and an individual physician or group of physicians, under which: (1) case management is the primary purpose; (2) hospital care services are available on a 24-hour basis.

services are not provided directly by or under contract to such a physician or group; (3) the physician or group receives at least 25% of its revenues from non-Medicaid and non-Medicare patients; (4) the Medicaid revenues that the physician or group would otherwise receive from the arrangement will not increase more than 20% as a result of a decrease in use by beneficiaries under case management of covered services; and (5) primary

Section 137(b)(22) This provision adds to the requirements under the home and community-based services waiver provision for an evaluation of an individual's need for services, that the State must also look at an individual's eligibility for such services.

Section 137(b)(26) This provision expands the circumstances under which the Secretary may impose a civil money penalty. Such circumstances now include physician violation of the terms of his assignment under Medicare and provider violation of an agreement with a State agency regarding maximum charges, in addition to the filing of claims for medical services not provided as claimed.

Section 137(c)(1) This provision amends the 1980 Reconciliation Act (P.L. 96-499) to make the coordinated audit requirement applicable to cost reporting periods beginning on or after April 1, 1981 rather than to services provided on or after that date.

Section 137(e) This provision clarifies that Christian Science Sanitoria are not required to meet medical review requirements.

In addition, in Section 128 certain corrections were made to technical errors in Title XVIII made in the Omnibus Budget Reconciliation Act of 1981.

Effective Date: These provisions are effective as if they had been originally included in the Reconciliation Act or Social Security Act provisions to which they relate, except as otherwise provided.